



AUTHORIZATION FOR RELEASE OF INFORMATION TO WIC

I _____ authorize _____
(Print Name) (Doctor, Nurse, Healthcare Provider, Hospital)

to release the following information about me or my child (indicate by checking the following boxes which information about you or your child you want to share with WIC):

- Medical diagnosis
- Recommended formula and feeding instructions
- Other health information as needed

to the Massachusetts WIC Program and the _____ local WIC Program located at (specify address):

for the purpose of assessing the need for special formula.

- I understand that I do not have to give authorization to my healthcare provider to share health information about me and/or my child with WIC but I want to.
- I understand that I can change my mind and cancel this authorization at any time. To do this, I need to write a letter to my healthcare provider and send it or bring it the place where I am now giving this authorization. Once the information has already been given out by my healthcare provider, I understand that it is too late for me cancel the authorization.

Authorized Signature: _____

Relationship to Participant: _____

Date: ____ / ____ / ____

This authorization is valid for 12 months after the above date.
WIC staff are required to follow federal law to protect WIC participant confidentiality and cannot re-disclose WIC applicant or participant information except with written consent or as required by law. WIC is an equal opportunity provider.